FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039826

Facility Name: Mount Vernon Care Center

Address: 1717 Jefferson Street (Number) Mount Vernon (City) 62864 (Zip Code)

County: Jefferson

Telephone Number: (618) 244-2861 **Fax #** (618) 244-7677

IDPA ID Number: 391516877002

Date of Initial License for Current Owners: 10/01/94

Type of Ownership:

[x]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[x]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501(c)(3)	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Michael G. Kaplan Telephone Number: (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/00 to 6/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)

(Print Name and Title) _____

(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606

(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	64	Intermediate (ICF)	64	23,360	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	64	TOTALS	64	23,360	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	16,732	3,617		20,349	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,732	3,617		20,349	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.11%

D. How many bed-hold days during this year were paid by Public Aid? 75 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/94

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 10/1/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified 0 and days of care provided n/a

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 6/30/01 Fiscal Year: 6/30/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	72,566	6,349	4,464	83,379		83,379		83,379			1
2	Food Purchase		83,249		83,249		83,249	(11,906)	71,343			2
3	Housekeeping	52,466	5,044		57,510		57,510		57,510			3
4	Laundry	36,962	5,450		42,412		42,412		42,412			4
5	Heat and Other Utilities			39,386	39,386		39,386	258	39,644			5
6	Maintenance	25,787		17,992	43,779		43,779	4,513	48,292			6
7	Other (specify):*											7
8	TOTAL General Services	187,781	100,092	61,842	349,715		349,715	(7,135)	342,580			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	498,394	15,020	852	514,266		514,266		514,266			10
10a	Therapy			781	781		781		781			10a
11	Activities	21,011	1,508	2,710	25,229		25,229	6,809	32,038			11
12	Social Services	17,547	46	1,648	19,241		19,241		19,241			12
13	Nurse Aide Training											13
14	Program Transportation			641	641		641		641			14
15	Other (specify):* Routine Dental			114	114		114		114			15
16	TOTAL Health Care and Programs	536,952	16,574	12,746	566,272		566,272	6,809	573,081			16
	C. General Administration											
17	Administrative	65,975		48,642	114,617		114,617	(48,642)	65,975			17
18	Directors Fees							12,459	12,459			18
19	Professional Services			6,615	6,615		6,615	39,323	45,938			19
20	Dues, Fees, Subscriptions & Promotions			4,072	4,072		4,072	512	4,584			20
21	Clerical & General Office Expenses	74,064	6,913	14,941	95,918		95,918	26,102	122,020			21
22	Employee Benefits & Payroll Taxes			79,290	79,290		79,290	127,982	207,272			22
23	Inservice Training & Education			29	29		29	1,197	1,226			23
24	Travel and Seminar			1,542	1,542		1,542	6,463	8,005			24
25	Other Admin. Staff Transportation			160	160		160	614	774			25
26	Insurance-Prop.Liab.Malpractice							35,597	35,597			26
27	Other (specify):*											27
28	TOTAL General Administration	140,039	6,913	155,291	302,243		302,243	201,607	503,850			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	864,772	123,579	229,879	1,218,230		1,218,230	201,281	1,419,511			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mount Vernon Care Center #0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			6,626	6,626		6,626	65,152	71,778			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,011	8,011		8,011	177,724	185,735			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			251,030	251,030		251,030	(243,944)	7,086			34
35	Rent-Equipment & Vehicles			4,585	4,585		4,585	3,229	7,814			35
36	Other (specify):* Insurance-MIP							9,842	9,842			36
37	TOTAL Ownership			270,252	270,252		270,252	12,003	282,255			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							1,521	1,521			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,040	35,040		35,040		35,040			42
43	Other (specify):* Nonallow. costs			3,155	3,155		3,155	(3,155)				43
44	TOTAL Special Cost Centers			38,195	38,195		38,195	(1,634)	36,561			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	864,772	123,579	538,326	1,526,677		1,526,677	211,650	1,738,327			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
**See schedule of adjustments attached at end of cost report

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(284)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	2,450	30		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,309)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(27)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,160)	43		24
25	Fund Raising, Advertising and Promotional	(486)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,198)	43		28
29	Other-Attach Schedule See Schedule 5A	(9,012)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (15,026)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	226,676		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 226,676		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 211,650		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Mount Vernon Care Center

ID# 0039826

Report Period Beginning: 7/1/00

Ending: 6/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Mount Vernon Care Center
Provider # 0039826
June 30, 2001

Schedule 5A

Schedule VI. Part A - Adjustment Detail, Line 29

Non-allowable expenses	Amount	Reference
Miscellaneous income offset	(368)	21
Non-allowable Chamber of Commerce dues	(287)	20
Out of period professional fees	(8,357)	19
Total	(9,012)	

See Accountants' Compilation Report

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mount Vernon Care Center # 0039826 **Report Period Beginning:** 7/1/00 **Ending:** 6/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	258	0	0	0	0	0	0	258	5
6	Maintenance	0	219	0	0	3,933	0	0	0	0	0	0	4,152	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	219	0	0	4,191	0	0	0	0	0	0	4,410	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	6,809	0	0	0	0	0	0	6,809	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	6,809	0	0	0	0	0	0	6,809	16
	C. General Administration													
17	Administrative	0	7,695	0	43,000	(99,337)	0	0	0	0	0	0	(48,642)	17
18	Directors Fees	0	3,200	0	9,259	0	0	0	0	0	0	0	12,459	18
19	Professional Services	0	7,857	0	0	27,710	12,113	0	0	0	0	0	47,680	19
20	Fees, Subscriptions & Promotions	0	409	0	177	166	47	0	0	0	0	0	799	20
21	Clerical & General Office Expenses	0	10,731	0	945	14,862	(68)	0	0	0	0	0	26,470	21
22	Employee Benefits & Payroll Taxes	0	32,971	0	74,501	8,604	0	0	0	0	0	0	116,076	22
23	Inservice Training & Education	0	0	0	0	1,197	0	0	0	0	0	0	1,197	23
24	Travel and Seminar	0	1,980	0	611	3,872	0	0	0	0	0	0	6,463	24
25	Other Admin. Staff Transportation	0	118	0	0	423	0	0	0	0	0	0	541	25
26	Insurance-Prop.Liab.Malpractice	0	187	0	100	499	35,245	0	0	0	0	0	36,031	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	65,148	0	128,593	(42,004)	47,337	0	0	0	0	0	199,074	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	65,367	0	128,593	(31,004)	47,337	0	0	0	0	0	210,293	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Mount Vernon Care Center **#** 0039826 **Report Period Beginning:** 7/1/00 **Ending:** 6/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,450	1,245	0	0	1,033	60,424	0	0	0	0	0	65,152	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,309)	1,477	0	419	10,598	170,539	0	0	0	0	0	177,724	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	7,085	(251,029)	0	0	0	0	0	(243,944)	34
35	Rent-Equipment & Vehicles	0	0	0	0	3,229	0	0	0	0	0	0	3,229	35
36	Other (specify):*	0	0	0	0	0	9,842	0	0	0	0	0	9,842	36
37	**TOTAL Ownership**	(2,859)	2,722	0	419	21,945	(10,224)	0	0	0	0	0	12,003	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	1,521	0	0	0	0	0	0	0	0	1,521	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(3,155)	0	0	0	0	0	0	0	0	0	0	(3,155)	43
44	**TOTAL Special Cost Centers**	(3,155)	0	1,521	0	0	0	0	0	0	0	0	(1,634)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(6,014)	68,089	1,521	129,012	(9,059)	37,113	0	0	0	0	0	220,662	45

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Caravilla Resident Centers, Inc. -	100.00%	See attached Related Party Schedule		See attached Related Party Schedule		
See attached Schedule 7A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Repairs & maintenance	$	Center for Residential Management, Inc.	**	$ 219	$ 219	1
2	V	11	Activity programming		Center for Residential Management, Inc.	**			2
3	V	17	Management fees	24,986	Center for Residential Management, Inc.	**	32,681	7,695	3
4	V	18	Board fees		Center for Residential Management, Inc.	**	3,200	3,200	4
5	V	19	Professional fees		Center for Residential Management, Inc.	**	7,857	7,857	5
6	V	20	Licenses, dues & subscriptions		Center for Residential Management, Inc.	**	409	409	6
7	V	21	Office supplies & telephone		Center for Residential Management, Inc.	**	10,731	10,731	7
8	V	22	Emp. benefits & payroll taxes		Center for Residential Management, Inc.	**	32,971	32,971	8
9	V	24	Travel & seminar		Center for Residential Management, Inc.	**	1,980	1,980	9
10	V	25	Vehicle expense		Center for Residential Management, Inc.	**	118	118	10
11	V	26	Vehicle, fire & liab. insurance		Center for Residential Management, Inc.	**	187	187	11
12	V	30	Depreciation		Center for Residential Management, Inc.	**	1,245	1,245	12
13	V	32	Interest expense		Center for Residential Management, Inc.	**	1,477	1,477	13
14	Total			$ 24,986			$ 93,075	$ * 68,089	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary service centers	$	Center for Residential Management, Inc.	**	$ 1,521	$ 1,521	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V				**Center for Residential Management, Inc. is				21
22	V				Caravilla Resident Centers, Inc.'s parent company.				22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 1,521	$ * 1,521	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management fees	$	Caravilla Resident Centers, Inc.	100.00%	$ 43,000	$ 43,000	15
16	V	18	Board fees		Caravilla Resident Centers, Inc.	100.00%	9,259	9,259	16
17	V	20	Licenses, dues & subscriptions		Caravilla Resident Centers, Inc.	100.00%	177	177	17
18	V	21	Office supplies & telephone		Caravilla Resident Centers, Inc.	100.00%	945	945	18
19	V	22	Emp. benefits & payroll taxes		Caravilla Resident Centers, Inc.	100.00%	74,501	74,501	19
20	V	24	Travel & seminar		Caravilla Resident Centers, Inc.	100.00%	611	611	20
21	V	26	Vehicle, fire & liab. insurance		Caravilla Resident Centers, Inc.	100.00%	100	100	21
22	V	32	Interest expense		Caravilla Resident Centers, Inc.	100.00%	419	419	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 129,012	$ * 129,012	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Developmental Services of Illinois, Inc.	**	$ 258	$ 258	15
16	V	6	Repairs & maintenance		Developmental Services of Illinois, Inc.	**	3,933	3,933	16
17	V	11	Activity programming		Developmental Services of Illinois, Inc.	**	6,809	6,809	17
18	V	17	Management fees	99,337	Developmental Services of Illinois, Inc.	**		(99,337)	18
19	V	19	Professional fees		Developmental Services of Illinois, Inc.	**	27,710	27,710	19
20	V	20	Licenses, dues & subscriptions		Developmental Services of Illinois, Inc.	**	166	166	20
21	V	21	Office supplies & telephone		Developmental Services of Illinois, Inc.	**	14,862	14,862	21
22	V	22	Emp. benefits & payroll taxes		Developmental Services of Illinois, Inc.	**	8,604	8,604	22
23	V	23	Inservice education		Developmental Services of Illinois, Inc.	**	1,197	1,197	23
24	V	24	Travel & seminar		Developmental Services of Illinois, Inc.	**	3,872	3,872	24
25	V	25	Vehicle expense		Developmental Services of Illinois, Inc.	**	423	423	25
26	V	26	Vehicle, fire & liab. insurance		Developmental Services of Illinois, Inc.	**	499	499	26
27	V	30	Depreciation		Developmental Services of Illinois, Inc.	**	1,033	1,033	27
28	V	32	Interest expense		Developmental Services of Illinois, Inc.	**	10,598	10,598	28
29	V	34	Rent expense		Developmental Services of Illinois, Inc.	**	7,085	7,085	29
30	V	35	Equipment rental		Developmental Services of Illinois, Inc.	**	3,229	3,229	30
31	V								31
32	V								32
33	V								33
34	V				**Developmental Services of Illinois, Inc. is Caravilla				34
35	V				Resident Centers, Inc.'s management company.				35
36	V								36
37	V								37
38	V								38
39	Total			$ 99,337			$ 90,278	$ * (9,059)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$	Caravilla Charitable Corporation	**	$ 12,113	$ 12,113	15
16	V	20	Licenses, dues & subscriptions		Caravilla Charitable Corporation	**	47	47	16
17	V	21	Office supplies & telephone		Caravilla Charitable Corporation	**	(68)	(68)	17
18	V	26	Vehicle, fire & liab. insurance		Caravilla Charitable Corporation	**	35,245	35,245	18
19	V	30	Depreciation		Caravilla Charitable Corporation	**	60,424	60,424	19
20	V	32	Interest expense		Caravilla Charitable Corporation	**	170,539	170,539	20
21	V	34	Rent expense	251,029	Caravilla Charitable Corporation	**		(251,029)	21
22	V	36	MIP insurance		Caravilla Charitable Corporation	**	9,842	9,842	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V				**Caravilla Charitable Corporation and Caravilla				28
29	V				Resident Centers, Inc. have the same parent company.				29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 251,029			$ 288,142	$ * 37,113	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Bauer	President	Board Member	None	12,712	2 hrs.mtg.		Directors Fees	$ 2,088	L18,C8	1
2	Roger Ryan	Vice President	Board Member	None	3,493	2 hrs.mtg		Directors Fees	1,307	L18,C8	2
3	William Armstrong	Treasurer	Board Member	None	3,493	2 hrs.mtg.		Directors Fees	1,307	L18,C8	3
4	Kay Baker	Secretary	Board Member	None	3,493	2 hrs.mtg		Directors Fees	1,307	L18,C8	4
5	Ronald O'Daniell	Director	Board Member	None	3,493	2 hrs.mtg		Directors Fees	1,307	L18,C8	5
6	Duane Satterwhite	Director	Board Member	None	3,620	2 hrs.mtg		Directors Fees	1,180	L18,C8	6
7	Merla McCloud	Recorder	Administrative	None	16,639	2 hrs mtg		Directors Fees	1,761	L18,C8	7
8	Ron Schroeder	Director	Board Member	None	14,346	2 hrs mtg		Directors Fees	454	L18,C8	8
9	Darrell Boehne	Director	Board Member	None	14,346	2 hrs mtg		Directors Fees	454	L18,C8	9
10	Edward Childers	Director	Board Member	None	14,033	2 hrs mtg		Directors Fees	567	L18,C8	10
11	Eugene Humphrey	Director	Board Member	None	4,528	2 hrs mtg		Directors Fees	272	L18,C8	11
12	Orland Bauer	Director	Board Member	None	8,345	2 hrs mtg		Directors Fees	455	L18,C8	12
13								TOTAL	$ 12,459		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Center for Residential Management, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Repairs & maintenance	Bed days available	205,860	20	$ 1,284	$	23,360	$ 146	1
2	17	Management fees	Bed days available	205,860	20	288,000		23,360	32,681	2
3	18	Board fees	Bed days available	205,860	20	28,200		23,360	3,200	3
4	19	Professional fees	Bed days available	205,860	20	69,236		23,360	7,857	4
5	20	Licenses, dues & subscriptions	Bed days available	205,860	20	270		23,360	31	5
6	21	Office supplies & telephone	Bed days available	205,860	20	18,491		23,360	2,098	6
7	22	Emp. benefits & payroll taxes	Bed days available	205,860	20	41,807		23,360	4,744	7
8	24	Travel & seminar	Bed days available	205,860	20	13,361		23,360	1,516	8
9	25	Vehicle expense	Bed days available	205,860	20	1,044		23,360	118	9
10	26	Vehicle, fire & liab. insurance	Bed days available	205,860	20	1,644		23,360	187	10
11	30	Depreciation	Bed days available	205,860	20	10,967		23,360	1,245	11
12	32	Interest expense	Bed days available	205,860	20	13,013		23,360	1,477	12
13	39	Ancillary service centers	Bed days available	205,860	20	13,408		23,360	1,521	13
14										14
15	6	Repairs & maintenance	Direct method						73	15
16	20	Licenses, dues & subscriptions	Direct method						378	16
17	21	Office supplies & telephone	Direct method						8,633	17
18	22	Emp. benefits & payroll taxes	Direct method						28,227	18
19	24	Travel & seminar	Direct method						464	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 500,725	$		$ 94,596	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Caravilla Resident Centers, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management fees	Number of beds	235	3	$ 137,000	$	64	$ 43,000	1
2	18	Board fees	Number of beds	235	3	33,999		64	9,259	2
3	20	Licenses, dues & subscriptions	Number of beds	235	3	650		64	177	3
4	21	Office supplies & telephone	Number of beds	235	3	3,463		64	945	4
5	22	Emp. benefits & payroll taxes	Number of beds	235	3	(6,223)		64	(1,620)	5
6	24	Travel & seminar	Number of beds	235	3	2,246		64	611	6
7	32	Interest expense	Number of beds	235	3	1,539		64	419	7
8										8
9										9
10	22	Emp. benefits & payroll taxes	Direct method						76,121	10
11	26	Vehicle, fire & liab. insurance	Direct method						100	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 172,674	$		$ 129,012	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Developmental Services of Illinois, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Bed days available	205,860	20	$ 2,273	$	23,360	$ 258	1
2	6	Repairs & maintenance	Bed days available	205,860	20	34,653		23,360	3,933	2
3	11	Activity programming	Bed days available	205,860	20	60,000		23,360	6,809	3
4	19	Professional fees	Bed days available	205,860	20	244,200		23,360	27,710	4
5	20	Licenses, dues & subscriptions	Bed days available	205,860	20	1,464		23,360	166	5
6	21	Office supplies & telephone	Bed days available	205,860	20	130,977		23,360	14,862	6
7	22	Emp. benefits & payroll taxes	Bed days available	205,860	20	75,816		23,360	8,604	7
8	23	Inservice education	Bed days available	205,860	20	10,547		23,360	1,197	8
9	24	Travel & seminar	Bed days available	205,860	20	34,127		23,360	3,872	9
10	25	Vehicle expense	Bed days available	205,860	20	3,724		23,360	423	10
11	26	Vehicle, fire & liab. insurance	Bed days available	205,860	20	4,401		23,360	499	11
12	30	Depreciation	Bed days available	205,860	20	9,100		23,360	1,033	12
13	32	Interest expense	Bed days available	205,860	20	93,395		23,360	10,598	13
14	34	Rent	Bed days available	205,860	20	62,438		23,360	7,085	14
15	35	Equipment rental	Bed days available	205,860	20	28,457		23,360	3,229	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 795,572	$		$ 90,278	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Continental Wingate		x	Purchase facility	$55,560.00	09/01/96	$ 7,402,500	$ 1,962,294	10/01/31	0.0855	$ 168,394	1
2	NCS Healthcare, Inc.		x	Hardware/Software	$689.00	10/31/98	27,579	11,836	09/30/03	0.1429	1,542	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$56,249.00		$ 7,430,079	$ 1,974,130			$ 169,936	9
	B. Non-Facility Related*											
10						Miscellaneous interest					5,166	10
11						Nonallowable interest expense and interest income offset					(10,493)	11
12						Amortization expense					4,617	12
13						Parent and management company allocation					16,509	13
14	TOTAL Non-Facility Related						$	$			$ 15,799	14
15	TOTALS (line 9+line14)						$ 7,430,079	$ 1,974,130			$ 185,735	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		N/A $	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mount Vernon Care Center COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0039826

CONTACT PERSON REGARDING THIS REPORT Rob Keime

TELEPHONE (309) 685-0595 FAX #: (309) 685-8463

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.	N/A		$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,500 B. General Construction Type: Exterior Brick Frame Block Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: n/a
2. Number of Years Over Which it is Being Amortized: n/a
3. Current Period Amortization: n/a
4. Dates Incurred: n/a

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	81,300	1994	$ 60,000	1
2					2
3	TOTALS	81,300		$ 60,000	3

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1994	1994	$ 1,229,600	$	40	$ 30,740	$ 30,740	$ 207,495	4
5			1998	1998	5,394		40	135	135	472	5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvements			1995	3,187		15	212	212	1,339	9
10	Architectural services			1996	4,794		15	320	320	1,400	10
11	Architectural services			1997	1,198		15	80	80	350	11
12	Air compressor			1996	1,230		15	82	82	359	12
13	Electrical			1996	1,710		15	114	114	499	13
14	Exit lighting			1997	1,354		15	90	90	394	14
15	Blinds, wallpaper & paint			1997	3,329		15	222	222	967	15
16	Waterproof basement			1997	7,822		15	521	521	2,280	16
17	Windows & doors			1997	2,878		15	192	192	840	17
18	Plastering			1997	20,386		15	1,359	1,359	5,946	18
19	Flooring			1997	4,544		15	303	303	1,060	19
20	Gutters			1997	8,933		15	596	596	2,086	20
21	Shutters & windows			1997	1,882		15	125	125	438	21
22	Remodeling of facility			1997	4,153		15	277	277	969	22
23	Plumbing			1997	15,420		15	1,028	1,028	3,598	23
24	Electrical service			1997	32,765		15	2,184	2,184	7,644	24
25	Paint & wallpaper			1997	8,366		15	558	558	1,953	25
26	Sidewalk			1997	780		15	52	52	182	26
27	Electrical service			1998	1,340		15	89	89	312	27
28	Flooring			1998	27,771		15	1,851	1,851	6,479	28
29	Remodeling of facility			1998	154		15	10	10	35	29
30	Paint & wallpaper			1998	262		15	17	17	60	30
31	Landscaping			1998	7,964		15	531	531	1,858	31
32	Windows			1998	1,599		15	107	107	374	32
33	Air conditioner			1998	578		15	39	39	137	33
34	Landscaping			1999	1,699		15	113	113	283	34
35	Cabinets			1999	1,220		15	81	81	203	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Renovation of nurse station	1999	$ 6,059	$	15	$ 404	$ 404	$ 1,010	37
38	Security System	1999	1,245		15	83	83	208	38
39	Water heater	1999	1,990	132	15	132		198	39
40	Remodel resident rooms	1999	3,343		15	222	222	333	40
41	Remodel resident rooms	1999	3,477		15	232	232	348	41
42	Remodel common room	1999	942		15	62	62	93	42
43	Remodel common room	1999	3,212		15	214	214	321	43
44	Trim	1999	671		15	44	44	66	44
45	Door	2000	984	66	15	66		99	45
46	Concrete Floor Pad	2000	1,500	50	15	50		50	46
47	Air Compressor	2001	1,803	60	15	60		60	47
48	Labor for building improvements	2000	13,971		15	931	931	931	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,441,509	$ 308		$ 44,528	$ 44,220	$ 253,729	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 220,241	$ 4,322	$ 22,748	$ 18,426	5-10 years	$ 120,617	71
72	Current Year Purchases	9,037	224	452	228	5-10 years	452	72
73	Fully Depreciated Assets							73
74	Parent and management company allocation			2,278	2,278			74
75	TOTALS	$ 229,278	$ 4,546	$ 25,478	$ 20,932		$ 121,069	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	1997 Ford E150*	1997	$ 13,040	$	$	$	3	$ 13,040	76
77	Resident Transportation	1997 GMC Van*	1999	5,315	1,772	1,772		3	4,430	77
78										78
79		* Cost allocated between 3 facilities								79
80	TOTALS			$ 18,355	$ 1,772	$ 1,772	$		$ 17,470	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,749,142	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 6,626	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 71,778	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 65,152	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 392,268	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Parent and management company allocation				7,086			6
7	TOTAL				$ 7,086 **			7

8. List separately any amortization of lease expense included on page 4, line 34. n/a
   This amount was calculated by dividing the total amount to be amortized n/a
   by the length of the lease n/a .

9. Option to Buy: ☐ YES ☒ NO Terms: n/a *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 4,905 Description: Dishwasher $1,487; Water Cooler $96; Misc. equipment $93; Mgmt. Co. allocation $3,229
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Care	1996 Chevy Lumina	$ 136.00	$ 1,634	17
18	Resident Care	1991 Ford Taurus Wagon	106.00	1,275	18
19					19
20					20
21	TOTAL		$ 242.00	$ 2,909	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Part B MCR supplies	L39, C8					1,521		1,521	13
14	TOTAL			$		$	$ 1,521		$ 1,521	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,021	$ 2,021	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 7,604)	159,892	159,892	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17	17	6
7	Other Prepaid Expenses	3,526	3,526	7
8	Accounts Receivable (owners or related parties)	373,633	373,633	8
9	Other(specify): Deposit	571	571	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 539,660	$ 539,660	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		60,000	13
14	Buildings, at Historical Cost		1,234,994	14
15	Leasehold Improvements, at Historical Cost	6,276	206,515	15
16	Equipment, at Historical Cost	36,803	247,633	16
17	Accumulated Depreciation (book methods)	(15,772)	(392,268)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	799	799	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Investment in Sub.	1,500	1,500	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 29,606	$ 1,359,173	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 569,266	$ 1,898,833	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 198,614	$ 198,614	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	46,185	46,185	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	124,630	124,630	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 369,429	$ 369,429	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	11,836	1,974,130	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 11,836	$ 1,974,130	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 381,265	$ 2,343,559	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 188,001	$ (444,726)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 569,266	$ 1,898,833	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Mount Vernon Care Center
Provider # 0039826
June 30, 2001

Schedule 17A

XV. Balance Sheet

	Operating	After Consolidation
Line 36 - Other		
Accrued Expense	1,225	1,225
Accrued Rent	32,068	32,068
Accrued Participation Fees	8,736	8,736
Resident Credit Balances	44,975	44,975
Prepaid Respro	30,014	30,014
Accrued Respro	7,612	7,612
Total	124,630	124,630

See Accountants' Compilation Report

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 359,975	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 359,975	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(5,188)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Parent & management co. allocation**		15
16	Other (describe) **added back in column 7**	(166,786)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (171,974)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 188,001	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,514,104	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,514,104	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,376	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,376	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	685	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,976	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,661	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	144	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 144	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	836	28
28a	Miscellaneous Income	368	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,204	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,521,489	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	349,715	31
32	Health Care	566,272	32
33	General Administration	302,243	33
	B. Capital Expense		
34	Ownership	270,252	34
	C. Ancillary Expense		
35	Special Cost Centers	3,155	35
36	Provider Participation Fee	35,040	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,526,677	40
41	**Income before Income Taxes (line 30 minus line 40)****	(5,188)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (5,188)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
A federal tax return is filed for the combined divisions of Caravilla Resident Centers, Inc.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,920	2,040	$ 31,305	$ 15.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,702	2,826	37,363	13.22	3
4	Licensed Practical Nurses	9,675	10,516	109,536	10.42	4
5	Nurse Aides & Orderlies	34,180	36,762	270,237	7.35	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,909	2,032	15,426	7.59	8
9	Activity Director					9
10	Activity Assistants	2,873	3,012	21,011	6.98	10
11	Social Service Workers	2,099	2,301	17,547	7.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,052	11,970	72,566	6.06	15
16	Dishwashers					16
17	Maintenance Workers	2,556	2,650	25,787	9.73	17
18	Housekeepers	7,722	8,334	52,466	6.30	18
19	Laundry	5,468	5,904	36,962	6.26	19
20	Administrator	1,896	2,072	37,565	18.13	20
21	Assistant Administrator					21
22	Other Administrative	1,185	1,244	28,410	22.84	22
23	Office Manager					23
24	Clerical	4,518	4,729	74,064	15.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	576	628	3,884	6.18	31
32	Other Health Ca See Sch 20A	2,536	2,672	30,643	11.47	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	92,867	99,692	$ 864,772 *	$ 8.67	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	105	$ 4,464	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	688	L10, C3	38
39	Pharmacist Consultant	Monthly	164	L10, C3	39
40	Physical Therapy Consultant	15	472	L10a, C3	40
41	Occupational Therapy Consultant	1	40	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	269	L10a, C3	43
44	Activity Consultant	36	1,662	L11, C3	44
45	Social Service Consultant	36	1,648	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	195	$ 15,407		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Mount Vernon Care Center
Provider # 0039826
June 30, 2001

Schedule 20A

XVII. A. Staffing and Salary Costs
Line 32 - Other Health Care

Title	Hours Worked	Hours Paid	Salaries	Average Hourly Wage
Care Plan Coordinator	1,960	2,032	26,682	13.13
Ancillary Clerk	576	640	3,961	6.19
Total	2,536	2,672	30,643	11.47

See Accountants' Compilation Report

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carrell Breeze	Administrator	0%	$ 37,565
Parent company allocation	See attached Schedule 21A		28,410
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 65,975

B. Administrative - Other

Description	Amount
Developmental Services of Illinois, Inc. - Management Fees	$ 23,656
Center for Residential Management, Inc. - Management Fees	24,986
(Management Fees are eliminated in column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 48,642
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/C Consulting	$ 785
Altschuler, Melvoin &	Accounting	2,825
Glasser LLP		
American Express Tax &	Accounting	1,360
Business Services		
Mangum, Smietanka & Johnson	Legal	757
Lawrence Manson	Legal	888
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 6,615

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,340
Unemployment Compensation Insurance	12,583
FICA Taxes	66,155
Employee Health Insurance	35,649
Employee Meals	11,906
Illinois Municipal Retirement Fund (IMRF)*	
Hepatitis B Shots	45
Employee Morale	4,594
TOTAL (agree to Schedule V, line 22, col.8)	$ 207,272

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	334
Health Care Worker Background Check	
(Indicate # of checks performed 76)	533
IHCA Dues	2,817
MES Dues	175
Management company allocation	228
Miscellaneous Dues and Licenses	297
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,584

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,288
Seminar Expense	1,328
Mgmt. & Parent company allocation	5,389
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,005

* Attach copy of IMRF notifications

**See instructions.

Mount Vernon Care Center
Provider # 0039826
June 30, 2001

Schedule 21C

XIX. Support Schedules
Section C. Professional Services, Page 21

Total (agrees to Schedule V, line 19 column 3)		6,615
Caravilla Charitable Corporation:		
Altschuler, Melvoin & Glasser LLP	Accounting	11,861
American Express Tax & Business Services	Accounting	189
Mangum, Smietanka & Johnson	Legal	63
Parent company allocation:		
Altschuler, Melvoin & Glasser LLP	Accounting	2,451
American Express Tax & Business Services	Accounting	1,236
Mangum, Smietanka & Johnson	Legal	2,642
Lawrence Manson	Legal	1,527
Management company allocation:		
Altschuler, Melvoin & Glasser LLP	Accounting	5,889
American Express Tax & Business Services	Accounting	2,809
ADP	Payroll Processing	10,195
Health Outcomes	Consulting	461
Total (agrees to Schedule V, line 19 column 8)		45,938

See Accountants' Compilation Report

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6								N/A					
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/00 Ending: 6/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $2,817**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **336** Line **10 (2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **35,040**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,906** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **45%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin and Glasser LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit is currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	72,566	6,349	4,464	83,379	0	83,379	0	83,379
2. Food Pu	0	83,249	0	83,249	0	83,249	-11,906	71,343
3. Housek	52,466	5,044	0	57,510	0	57,510	0	57,510
4. Laundry	36,962	5,450	0	42,412	0	42,412	0	42,412
5. Heat an	0	0	39,386	39,386	0	39,386	258	39,644
6. Mainten	25,787	0	17,992	43,779	0	43,779	4,513	48,292
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	187,781	100,092	61,842	349,715	0	349,715	-7,135	342,580
9. Medical	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursin	498,394	15,020	852	514,266	0	514,266	0	514,266
10a. Thera	0	0	781	781	0	781	0	781
11. Activiti	21,011	1,508	2,710	25,229	0	25,229	6,809	32,038
12. Social	17,547	46	1,648	19,241	0	19,241	0	19,241
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	641	641	0	641	0	641
15. Other	0	0	114	114	0	114	0	114
16. Total H	536,952	16,574	12,746	566,272	0	566,272	6,809	573,081
17. Admin	65,975	0	48,642	114,617	0	114,617	-48,642	65,975
18. Directo	0	0	0	0	0	0	12,459	12,459
19. Profes	0	0	6,615	6,615	0	6,615	39,323	45,938
20. Fees,	0	0	4,072	4,072	0	4,072	512	4,584
21. Clerica	74,064	6,913	14,941	95,918	0	95,918	26,102	122,020
22. Emplo	0	0	79,290	79,290	0	79,290	127,982	207,272
23. Inservi	0	0	29	29	0	29	1,197	1,226
24. Travel	0	0	1,542	1,542	0	1,542	6,463	8,005
25. Other	0	0	160	160	0	160	614	774
26. Insura	0	0	0	0	0	0	35,597	35,597
27. Other	0	0	0	0	0	0	0	0
28. Total G	140,039	6,913	155,291	302,243	0	302,243	201,607	503,850
29. Total G	864,772	123,579	229,879	1,218,230	0	1,218,230	201,281	1,419,511
30. Depre	0	0	6,626	6,626	0	6,626	65,152	71,778
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	8,011	8,011	0	8,011	177,724	185,735
33. Real E	0	0	0	0	0	0	0	0
34. Rent -	0	0	251,030	251,030	0	251,030	-243,944	7,086
35. Rent -	0	0	4,585	4,585	0	4,585	3,229	7,814
36. Other	0	0	0	0	0	0	9,842	9,842
37. Total G	0	0	270,252	270,252	0	270,252	12,003	282,255
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	0	0	0	0	0	1,521	1,521
40. Barber	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	35,040	35,040	0	35,040	0	35,040
43. Other	0	0	3,155	3,155	0	3,155	-3,155	0
44. Total S	0	0	38,195	38,195	0	38,195	-1,634	36,561
45. Grand	864,772	123,579	538,326	1,526,677	0	1,526,677	211,650	1,738,327

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	2,021	2,021
2. Cash - F	0	0
3. Account	159,892	159,892
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	17	17
7. Other Pr	3,526	3,526
8. Account	373,633	373,633
9. Other (s	571	571
10. Total cı	539,660	539,660
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	0	60,000
14. Buildin	0	1,234,994
15. Leaseh	6,276	206,515
16. Equipm	36,803	247,633
17. Accum	-15,772	-392,268
18. Deferre	0	0
19. Organi:	799	799
20. Accum	0	0
21. Restric	0	0
22. Other L	0	0
23. other (s	1,500	1,500
24. Total L	29,606	1,359,173
25. Total A	569,266	1,898,833
CURRENT LIABILITIES		
26. Accour	198,614	198,614
27. Officer'	0	0
28. Accour	0	0
29. Short-T	0	0
30. Accrue	46,185	46,185
31. Accrue	0	0
32. Accrue	0	0
33. Accrue	0	0
34. Deferre	0	0
35. Federa	0	0
36. Other C	124,630	124,630
37. Other C	0	0
38. Total C	369,429	369,429
LONG TERM LIABILITES		
39.Long-Te	11,836	1,974,130
40.Mortgag	0	0
41.Bonds F	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	11,836	1,974,130
46.Total Li	381,265	2,343,559
47.Total Ec	188,001	-444,726
48.Total Li	569,266	1,898,833

		Balance per Medicaid Trial Balance
1.	Gross F	1,514,104
2.	Discour	0
	Subtota	1,514,104
4.	Day Ca	0
5.	Other C	0
6.	Therapy	1,376
7.	Oxygen	0
	Subtota	1,376
9.	Paymer	0
10.	Other	0
11.	Nurses	0
12.	Gift an	0
13.	Barber	0
14.	Non-P	685
15.	Teleph	0
16.	Rental	0
17.	Sale o	0
18.	Sale o	0
19.	Labora	0
20.	Radiol	0
21.	Other	3,976
22.	Laund	0
	Subtot	4,661
24.	Contril	0
25.	Interes	144
	Subtot	144
27.	Other	0
28.	Other	1,204
	Subtot	1,204
30.	Total F	1,521,489
31.	Gener	372,357
32.	Health	1,193,342
33.	Gener	496,661
34.	Owner	241,915
35.	Specia	213,124
35.	Provid	35,686
37.	Other	0
40.	Total E	2,553,085
41.	Incom	########
42.	Incom	0
43.	Net In	########

Page

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9
10 Attachment of Real Estate Bill and fill out form

11
12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Mount Vernon Care Cen** **03:36 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	211,650	equal to	211,650	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	185,735	equal to	185,735	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	n/a	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	71,778	equal to	71,778	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	7,086	equal to	7,086	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	7,814	equal to	7,814	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	781	equal to	781	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	1,521	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	349,715	equal to	349,715	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	566,272	equal to	566,272	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	302,243	equal to	302,243	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	270,252	equal to	270,252	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	3,155	equal to	3,155	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	35,040	equal to	35,040	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	452,325	equal to	498,394	-46,069	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	21,011	equal to	21,011	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	17,547	equal to	17,547	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	72,566	equal to	72,566	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	25,787	equal to	25,787	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	52,466	equal to	52,466	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	36,962	equal to	36,962	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	65,975	equal to	65,975	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	74,064	equal to	74,064	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	864,772	equal to	864,772	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	4,464	< or = to	4,464	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	852	< or = to	852	0	O.K.	Pg20 X14..X16+	B. & C.	:7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,662	< or = to	2,710	-1,048	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,648	< or = to	1,648	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	65,975	equal to	65,975	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	48,642	equal to	48,642	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	6,615	equal to	6,615	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	207,272	equal to	207,272	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	4,584	equal to	4,584	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	8,005	equal to	8,005	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	35,040	equal to	35,040	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	11,906	< or = to	127,982	-116,076	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	11,906	equal to	11,906	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	n/a	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	226,676	equal to	226,676	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	1,974,130	equal to	1,974,130	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	60,000	equal to	60,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,441,509	equal to	1,441,509	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	247,633	equal to	247,633	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	392,268	equal to	392,268	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	188,001	equal to	188,001	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-5,188	equal to	-5,188	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	569,266	equal to	569,266	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1